STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 01 B. WING	08/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/29/11 Facility Number: 009569 Provider Number: 155628 AIM Number: 200139920 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Briarwood Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas not separated from the corridor. The facility has a capacity of	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	113 and had a census of 92 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/02/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 2 of 2 openings through 1 of 5 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed	K0025	1. The door has been repaired and now shuts. The gap in the wall has been fire chalked.2. All residents in the vicinity of the smoke barrier wall between the main entrance reception areas and corridor to the 300 hall had the potential to be affected.3. The Maintenance Director will inspect the attic monthly to ensure no breaches have occurred.4. Results of the monthly inspections will be documented on the facility's TELS system. Results of the inspections will be presented to the Quality	09/28/2011

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	for the specific purpose. This deficient practice could affect any resident, staff or visitor in the vicinity of the smoke barrier wall between the main entrance reception area and the corridor leading to the 300 Hall. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 11:10 a.m. to 1:25 p.m. on 08/29/11, the following was noted: a) The smoke barrier wall in the attic above the corridor from the 300 Hall to the main entrance reception area had a square access door in the wall measuring three feet by two which was in the open position. The Director of Maintenance tried to close and secure the door but a wooden two by four in the attic ceiling blocked the door from being closed. b) The attic smoke barrier wall above the corridor from the 300 Hall to the main entrance reception area had ten wires penetrating through the concrete block wall with a one inch gap which was not firestopped. Based on interview at the time of observations, the Director of Maintenance acknowledged the smoke barrier wall in the attic above the corridor from the 300 Hall to the main entrance reception area had a open access door in the smoke wall		Assurance Committee monthly.5. Correction completed: 9-28-11	

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	which was obstructed from closing and acknowledged a one inch gap in the wall which was not firestopped. 3.1-19(b)			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 7 doors serving hazardous areas such as the kitchen are provided with a positive latching device to latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the north door to the kitchen. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 11:10 a.m. to 1:25 p.m. on 08/29/11, the north door to the kitchen was not equipped with a positive latching device to latch the door into the door frame.	K0029	1. A positive latching device to latch the door to the door frame was installed by the Maintenance Director.2. Any resident in the vicinity of the north door to the kitchen had the potential to be affected.3. The maintenance Director will perform weekly checks and will be documented on the facility's TELS system.4. Results of the inspection will be presented to the Quality Assurance Committee monthly.5. Correction completed: 9-28-11	09/28/2011

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	Based on interview at the time of observation, the Director of Maintenance acknowledged the north door to the kitchen is not equipped with a positive latching mechanism to latch the door into the door frame. 3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 1. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 3 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Monthly Fire and	K0050	1. An annual fire drill schedule that meets regulation has been set up on the facility's TELS System. The TELS System has a Fire drill/Evacuation form that has the time, date, shift, drill or alarm and scenario of each fire drill. 2. All residents had the potential to be affected by this practice.3. The Administrator will review the TELS schedule, TELS system, Fire drill/evacuation form.4. The Administrator will present the results of the review to the Quality	09/28/2011

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	Evacuation Alarm/Drill Record" documentation with the Director of Maintenance from 9:25 a.m. to 11:10 a.m. on 08/29/11, four of five second shift fire drills conducted between 10/12/10 and 08/05/11 were conducted between 3:35 p.m. and 3:40 p.m. Based on interview at the time of record review, the Director of Maintenance acknowledged second shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b) 2. Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 2 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Monthly Fire and Evacuation Alarm/Drill Record" documentation with the Director of Maintenance from 9:25 a.m. to 11:10 a.m. on 08/29/11, there is no documentation available for review for fire drills conducted on the third shift for the fourth quarter of 2010 or the first quarter of 2011. Based on interview at the time of record review, the Director of		Assurance Committee quarterly.5. Correction completed: 9-28-11	

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	Maintenance acknowledged there was no documentation available for review of fire drills being conducted on the third shift for the fourth quarter of 2010 and the first quarter or 2011. 3.1-19(b)			
K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet was: 1) separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. 2) separated from a minimum distance of at least five feet from combustible materials. NFPA 99, 8-3.1.11.2(c) requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet if the required storage	K0076	1. The Maintenance Director installed a 5/8 inch drywall on both sides of the existing barrier that had been previously installed over a previous door opening. This will provide a 1 hour rating, as well as provide a 1 hour fire resistive construction separating the oxygen storage and transferring room from combustive materials.2. Any resident in the vicinity of the oxygen storage and transfilling room had the potential to be affected.3. The maintenance Director will inspect the oxygen rooms quarterly to provide assurance the storage rooms are meeting regulatory requirements.	09/28/2011

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	location is protected by an automatic sprinkler system. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 11:10 a.m. to 1:25 p.m. on 08/29/11, the oxygen storage and transfilling room contained five liquid oxygen canisters. The north wall of the oxygen storage and transfilling room had a wooden board 78 inches tall and 36 inches wide secured into a former door frame. The secured board was not fire rated and served as a wall between the oxygen storage and transfilling room and the nurse's station which is open to the corridor. In addition, the liquid oxygen storage canisters were stored within five feet of the wooden wall board. Based on interview at the time of observation, the Director of Maintenance stated the wooden wall board replaced a former door from the nurse's station to the oxygen storage and transfilling room and acknowledged the wooden wall board did not provide one hour fire resistive construction and acknowledged combustible materials were stored within five feet of the liquid oxygen canisters.		This will be documented on the facility's TELS system.4. Results of the inspection will be presented to the Quality Assurance Committee quarterly for compliance.5. Correction completed: 9-28-11	

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	3.1-19(b)			
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 2 of 2 areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: a. Based on observation with the Director of Maintenance during a tour of the facility from 11:10 a.m. to 1:25 p.m. on 08/29/11, the oxygen storage and	K0143	1. a. The Maintenance Director installed a 5/8 inch drywall on both sides of the existing barrier that had been previously installed over a previous door opening. This will provide a 1 hour rating, as well as provide a 1 hour fire resistive construction separating the oxygen storage and transferring room from combustive materials. b. When residents are on leave from the facility the liquid oxygen canisters will be placed in the oxygen storage and transfilling room. 2. All residents in the vicinity have the potential to be affected.3. a. The Maintenance Director will inspect the oxygen rooms monthly to provide assurance the storage rooms are meeting regulatory requirements. This will	09/28/2011

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	transfilling room contained five liquid oxygen canisters. The north wall of the oxygen storage and transfilling room had a wooden board 78 inches tall and 36 inches wide secured into a former door frame. The secured board was not fire rated and served as a wall between the oxygen storage and transfilling room and the nurse's station which is open to the corridor. Based on interview at the time of observation, the Director of Maintenance stated the wooden wall board replaced a former door and acknowledged the wooden wall board did not provide one hour fire resistive construction. b. Based on observation with the Director of Maintenance during a tour of the facility from 11:10 a.m. to 1:25 p.m. on 08/29/11, Room 204 had one stationary liquid oxygen storage canister in a resident room. The stationary liquid oxygen canister was 25% full and was not in use by the resident who was not in the room. Based on interview with the Acting Administrator at 1:20 p.m. on 08/29/11, the Acting Administrator stated the resident had a clinical need to utilize the stationary liquid oxygen storage canister in the resident room but acknowledged the resident may leave the facility on a daily basis for other treatment. The Director of Maintenance and the Acting Administrator acknowledged the liquid		be documented on the facility's TELS system. b. Liquid oxygen canisters will only be used for continous treatment orders, all other residents with oxygen needs will have concentrator provided. The charge nurse or designee will monitor and remove all liquid oxygen canisters not in use daily during respiratory change over rounds.4. All results will be presented to the Quality Assurance Committee quarterly for compliance.5. Correction completed: 9-28-11	

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	oxygen canister observed in Room 204 was not in use by the resident in Room 204. 3.1-19(b)			